



**Department of Insurance**  
**REGULATION 1301 (Formerly Regulation 11)**

**ARBITRATION OF HEALTH INSURANCE CLAIMS AND INTERNAL REVIEW  
PROCESSES OF MEDICAL INSURANCE CARRIERS**

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**Section 1. Purpose and Statutory Authority**

The purpose of this Regulation is to implement 16 *Del. C.* § 9119, 18 *Del. C.* §§ 332, 3348, 3559E, and 18 *Del. C.* Chapter 23 by establishing the procedures for the arbitration of certain claims for benefits available under health insurance policies or agreements, and/or the explicit provisions of the statutes under which this regulation is promulgated. This Regulation is promulgated pursuant to 18 *Del. C.* §§ 311, 2312, and 29 *Del. C.*, Ch. 101 and 73 *Del. Laws* Chapter 96. This Regulation should not be construed to create any cause of action not otherwise existing at law.

**Section 2. Definitions**

Except as otherwise noted, the following definitions shall apply:

- 2.1 "Commissioner" shall mean the Insurance Commissioner of Delaware.
- 2.2 "Department" shall mean the Delaware Insurance Department.
- 2.3 "Emergency care service" shall have the same meaning as contained in 18 *Del. C.* §§ 3348(c) and 3559E and include:
  - 2.3.1 any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met; and
  - 2.3.2 facility and professional providers of emergency medical services in an

- approved emergency care facility.
- 2.4 "Emergency medical condition" shall have the meaning assigned to it by 18 *Del. C.* §§ 3348(d) and 3559E(b).
- 2.5 "Health insurance policy" shall have the meaning assigned to it by 18 *Del. C.* § 332(a)8.
- 2.6 "Insured" shall, in addition to its ordinary meaning, include the participants, subscribers or members of such health plans, health service corporations, medical care organizations or health maintenance organizations.
- 2.7 "Insurer" or "carrier," in addition to its ordinary meaning under 18 *Del. C.* § 3343(a)(1), includes health plans, health service corporations, medical care organizations and health maintenance organizations subject to state insurance regulation.
- 2.8 "IRP" shall mean an internal review process established by an insurer under 18 *Del. C.* § 332.
- 2.9 "Network insurer" is an insurer who has a written participation agreement with the provider to pay for emergency care services in Delaware on and after January 1, 2002.
- 2.10 "Network provider" is a provider who has a written participation agreement with the insurer to provide emergency care services or governing payment of emergency care services in Delaware as of the date those services were provided. All other providers of emergency care services shall be considered non-network providers.
- 2.11 "Provider" means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides an emergency care service in this State after January 1, 2002.

### **Section 3. Insurer's Duty to Arbitrate**

Except for claims exempt from arbitration by law or regulation, every insurer, carrier, provider, network provider and non-network provider giving or providing health and/or emergency medical services, and/or health insurance coverage or benefits in this State shall submit to arbitration as follows:

- 3.1 covered claims arising from the provision of emergency services under 18 *Del. C.* §§ 3348 and 3559E; and
- 3.2 appeals from decisions of an IRP under 18 *Del. C.* § 332 by the insured.

### **Section 4. Exemption from Arbitration**

- 4.1 Health claims or appeals which involve issues of medical necessity and/or the appropriateness of services, as defined in 16 *Del. C.* § 9119, shall be exempt from arbitration by the Department. Any claims or appeals filed with the Department shall be deemed properly filed if actually received by the Department within in the allotted statutory time and such appeals shall, within 7 days from the date the Department determines that such appeals are exempt or excluded from arbitration, be forwarded by the Department through normal state channels to the Department of Health and Social Services, or its appropriate successor agency, for external

review under 16 *Del. C.* § 9119 and such other laws and regulations as are applicable to said claims or appeals.

- 4.2 18 *Del. C.* §§ 3348(b) and 3559E(b) shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On or before July 1, 2002, and quarterly thereafter, each insurer shall provide a list of non-exempt plan numbers, as defined in 18 *Del. C.* §§ 3348(b) and 3559E(b) to the Department. The Department shall maintain a public register of such non-exempt plan numbers. The placement of a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is subject to the provisions of this regulation. An insurer that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this subsection but only with respect to the plans for which such identification or membership cards display the group status.
- 4.3 The provisions of this regulation shall not apply to Medicaid or any other health insurance coverage program where the review of coverage determinations are otherwise regulated by the provisions of other state or federal laws or regulations.

## **Section 5. Exclusion from Arbitration**

- 5.1 The following claims shall not be subject to arbitration under this regulation:
  - 5.1.1 Claims for which there is no jurisdiction under 18 *Del. C.* § 332.
  - 5.1.2 Claims that are already pending before any court or other administrative agency; or
  - 5.1.3 Claims that have been exempted by the Commissioner under Section 4 of this regulation.
- 5.2 The Arbitration Secretary or arbitrator is authorized to dismiss a matter upon receipt of information sufficient to establish that the claim is excluded under subsection 5.1 and after notice and an opportunity to respond is provided the claimant.

## **Section 6. Minimum Requirements for an Internal Review Process (IRP)**

In addition to the requirements set forth in 18 *Del. C.* § 332, the following provisions shall govern the internal review process of all insurers offering health coverage in Delaware:

- 6.1 All written procedures and forms utilized by a insurer shall be readable and understandable by a person of average intelligence and education. All such documents shall meet the following criteria:
  - 6.1.1 The type size shall not be smaller than 11 point;
  - 6.1.2 The type style selection shall be at the discretion of the insurer but shall be of a type that is clear and legible;
  - 6.1.3 Captions or headings shall be designed to stand out clearly;
  - 6.1.4 White space separating subjects or sections should be distinct;
  - 6.1.5 There must be included a table of contents sufficient to guide and assist the insured;
  - 6.1.6 Where appropriate, definitions shall be included and shall be sufficient to clearly apply to the usage intended.

- 6.1.7 The forms shall be written in everyday, conversational language to the extent possible to preserve the legal meaning.
- 6.1.6 Short familiar words shall be used and sentences shall be kept as short and simple as possible.
- 6.2 All forms relating to grievances, appeals, or other procedures relating to the IRP shall be provided as examples along with the written IRP provided to the insured by the insurer.
- 6.3 The first notice of an IRP shall be given to all insureds of an insurer within thirty (30) days of approval by the Commissioner. The annual notice thereafter shall either be upon the policy renewal date, open enrollment date, or a set date for all insureds of the insurer, at the insurer's discretion. For every new policy issued after the approval of the IRP by the Commissioner, the insurer shall provide a copy of the IRP at the time, or prior to the time, the insurer sends identification cards, member handbooks or similar member materials to newly insured participants. When the insured's dependents reside in the same household as the insured, a single notice to the principal insured shall be sufficient under this section.
- 6.4 Under circumstances where an oral or written grievance may not contain sufficient information and the insurer requests additional information, such request shall not be burdensome or require such information as the insurer might reasonably be expected to obtain through its normal claims process.

## **Section 7. Mediation Services**

At the time the insurer provides a written notice of an unfavorable disposition of a claim or grievance to an insured, the insurer shall provide the insured with a written notice of mediation services offered by the Delaware Insurance Department. Such notice may be separate from or a part of the written notice of disposition of a claim or grievance. Any notice provided to an insured shall, at a minimum, contain the following information:

You have the right to appeal a claim denial for medical reasons to the Delaware Department of Health and Social Services or to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

## **Section 8. Payments for Emergencies Based on Date of Service**

Under 18 *Del. C.* §§ 3348 and 3559E the Commissioner shall be responsible for setting rates and charges in the event of a dispute between an insurer and a provider. In an arbitration pursuant to said statutes, the Arbitrator shall consider the following guidelines

as a basis for determining the rate or charge for a disputed service unless the evidence adduced under section 9.5 at arbitration requires a determination on a different basis.

- 8.1 *Payments for existing emergency care services as of July 1, 2002.* Effective on July 1, 2002, under circumstances where the contract between the provider and insurer was terminated after January 1, 2002, insurers will pay such provider the highest contract rate for the services provided during the term of the contract for services identified in 18 *Del. C.* §§ 3348 or 3559E, adjusted annually to reflect changes in payments by that insurer to its network providers and subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time. Effective on July 1, 2002, insurers will pay non-network providers who were not network providers on or after January 1, 2002 the higher of either (1) the highest payment rate paid by the insurer to the non-network provider for performance of the same service; or (2) the highest undisputed amount regularly paid by any network insurer to the non-network provider for performance of the same service. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.
- 8.2 *Payments for new emergency care services after July 1, 2002.* Each insurer shall pay non-network providers for each emergency medical care service after July 1, 2002, an amount equal to the lesser of the non-network provider billed fee for such new service or the highest negotiated rate between the insurer and any network provider for the service based on the appropriate CPT code until such time as the provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.
- 8.3 *Payments for new emergency care services that receive CPT codes on or after July 1, 2002.* Effective on or after July 1, 2002, for services that do not have a CPT code or other identifiable code number, each insurer shall pay non-network providers the lesser of: the provider billed fee, or the highest negotiated network rate received by the provider from any insurer for the performance of the same service. When and if the provider becomes a network provider with insurer, payments will be based on the negotiated rate.
- 8.4 Subsequent to January 1, 2002, changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this section to payments for emergency services. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.

## **Section 9. General Procedures Applicable to Arbitrations**

- 9.1 In arbitration proceedings and practice, the person(s), firm(s) or entity(ies) who initiates the proceeding by filing a petition for arbitration of a disputed claim or issue with the Commissioner shall be known as the "claimant(s)," and the person(s), firm(s) or entity(ies) against whom such claim or claims is asserted shall be known as "respondent(s)."
- 9.2 A petition for arbitration shall be in writing and filed in the office of the Commissioner on or before the sixtieth day following the claimant's receipt of the written adverse determination or denial.

- 9.3 The parties must provide a brief statement verifying the service of all filed papers with the manner, date and address of service. A verification of service using Form C in the appendix to this Regulation shall be satisfactory if mailed to the opposing party as required by this Regulation.
- 9.4 Notice and Manner of Service.
  - 9.4.1 Notice and manner of service, except service of the original petition, is sufficient and complete if properly addressed, upon mailing the same with prepaid first class U.S. Postage.
  - 9.4.2 Service of an original petition shall be by Certified U.S. Postage and Return receipt requested or hand delivery to the respondent and is complete upon receipt by addressee or an employee in respondent's place of business.
- 9.5 In any arbitration pursuant to 18 *Del. C.* §§ 3348 or 3559E, the Arbitrator shall, at a minimum, receive evidence relating to the following items:
  - 9.5.1 The highest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;
  - 9.5.2 The lowest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;
  - 9.5.3 The highest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;
  - 9.5.4 The lowest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;
  - 9.5.5 The number of times during the preceding twelve months that the insurer experienced a dispute or disagreement with respect to the payment for the particular service in a comparable medical facility where the service was provided and the outcome of such disputes or disagreements.
  - 9.5.6 Such information as may be provided to the Arbitrator pursuant to an arbitration shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration. Likewise, any personal health information introduced into evidence as part of the arbitration shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.
- 9.6 In arbitrations commenced under 18 *Del. C.* § 332, the insurer shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.
- 9.7 In arbitrations commenced under 18 *Del. C.* §§ 3348 or 3559E, the non-prevailing party(ies) shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.

## **Section 10. Commencement of Arbitration**

- 10.1 An arbitration will commence upon the filing of an original and three copies of a petition, in acceptable form with the Commissioner's Arbitration Secretary with the supporting documents or other evidence attached thereto and payment of the non-refundable filing fee of \$75.00. The claimant shall, at the same time, send a copy of the petition and supporting documents to the respondent as required in Section 9. The Arbitration Secretary may refuse to accept any petition which fails to meet the jurisdictional requirements for arbitration. The failure to file a petition which meets the jurisdictional requirements for arbitration shall not toll the time allowed to file for arbitration.
- 10.2 Within 20 days of receipt of the petition, the respondent shall file an original and three copies of a response, in acceptable form, with the Arbitration Secretary with supporting documents or other evidence attached. The respondent shall, at the same time, send a copy of the response and supporting documents to the claimant as required in Section 9. The Arbitration Secretary may return any non-conforming response. If the Arbitration Secretary or Arbitrator determines at any time that the petition fails to meet the jurisdictional requirements of the statute or this regulation or is meritless on its face, the petition may be summarily dismissed by the Arbitration Secretary or Arbitrator and notice of such dismissal shall be provided to the parties. The non-prevailing party may seek to have the petition re-opened under the provisions of subsection 10.3 of this section.
- 10.3 If the respondent fails to file a response in a timely fashion, the Arbitration Secretary after verifying proper service and notice to the parties may assign the matter to the next scheduled Arbitrator for summary disposition. The Arbitrator may determine the matter in the nature of a default judgment after establishing that the petition is properly supported and was properly served on respondent. The Arbitration Secretary or Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than 7 days after notice of the default judgment.
- 10.4 Upon the filing of a proper response, the Arbitration Secretary shall assign and schedule the matter for a hearing before an Arbitrator.

## **Section 11. Arbitration**

The Commissioner shall appoint a single arbitrator of suitable background and experience to hear any case presented for arbitration under this regulation. No arbitrator may be selected where the arbitrator's employer or client is a party. The Arbitrator shall act as the Commissioner's designee and shall issue a written opinion as required by 29 *Del. C.* § 10126.

## **Section 12. Arbitration Hearings**

- 12.1 The arbitration hearing shall be scheduled and notice of the hearing shall be given the parties at least 10 days prior to the hearing. Neither party is required to appear and may rely on the filed papers.
- 12.2 The purpose of Arbitration is an attempt to effect a prompt and inexpensive resolution of claims after reasonable attempts by the parties to resolve the matter. In keeping with that goal arbitration hearings shall be conducted in accordance

with the provisions of the 29 *Del. C.* Chapter 101. The arbitration hearing is not a substitute for a civil trial. Accordingly, The Delaware Rules of Evidence will be used for general guidance but will not be strictly applied. Hearings are to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence in support of the pleading and to answer questions by the Arbitrator. If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross examination or other response by the opposing party. Because the testimony may involve evidence relating to personal health information that is confidential and protected by other state or federal laws from public disclosure, the arbitration hearings shall be closed unless otherwise agreed by the parties.

- 12.3 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.
- 12.4 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least 5 days notice, except claims of a continuing nature which are set out in the filed papers.
- 12.5 The Arbitrator shall render its decision and mail a copy of the decision to the parties within 45 days of the filing of the petition.

### **Section 13. Appeals**

- 13.1 Appeals from an adverse decision of the Arbitrator shall be taken to the Superior Court of the State of Delaware by filing a copy of the Notice of Appeal, as filed in the Superior Court, with the Arbitration Secretary.
- 13.2 The Rules of Civil Procedure of the Superior Court shall govern all appeal procedures.
- 13.3 Any appeal which, as a matter of law, has to be filed in a court other than the Superior Court, shall be subject to the rules of such court and the appellant shall file a copy of the Notice of Appeal to such court with the Arbitration Secretary.

### **Section 14. Confidentiality of Health Information**

Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

### **Section 15. Effective Date**

This regulation shall become effective on the 11th day of March, 2002.

ADOPTED AND SIGNED BY THE COMMISSIONER

February 15, 2002



**APPENDIX**  
**REGULATION 11—FORM A**  
**PETITION FOR HEALTH INSURANCE ARBITRATION**

YOUR NAME \_\_\_\_\_  
YOUR ADDRESS \_\_\_\_\_  
YOUR TELEPHONE NUMBER \_\_\_\_\_  
WERE YOU: \_\_\_\_\_ Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Parent or Guardian \_\_\_\_\_ Power of Attorney \_\_\_\_\_ Other

NAME OF THE INSURANCE CO. AGAINST WHICH YOU ARE MAKING A CLAIM \_\_\_\_\_

CASE NUMBER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TELEPHONE NUMBER \_\_\_\_\_

NAME OF THE POLICYHOLDER IF OTHER THAN YOU \_\_\_\_\_  
ADDRESS, IF DIFFERENT FROM ABOVE \_\_\_\_\_

DATE OF DETERMINATION OF INDEPENDENT REVIEW PROCESS \_\_\_\_\_

AMOUNT OF YOUR CLAIM \_\_\_\_\_  
DATES OF SERVICE (FROM) \_\_\_\_\_ (TO) \_\_\_\_\_

BRIEFLY DESCRIBE THE BASIS FOR YOUR CLAIM AND ATTACH THE NOTIFICATION OR EXPLANATION OF BENEFITS YOU RECEIVED FROM THE INSURANCE COMPANY.

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**PRIOR TO THE HEARING, IT IS NECESSARY THAT YOU SUBMIT THE APPROPRIATE DOCUMENTS TO SUPPORT YOUR PETITION TO THE DELAWARE INSURANCE DEPARTMENT AND TO THE OPPOSING PARTY.**

PARTIES MAY PRESENT WITNESSES IN THEIR BEHALF AT THE HEARING PROVIDED THAT DUE NOTICE IS GIVEN. PLEASE LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL WITNESSES YOU EXPECT TO APPEAR ON YOUR BEHALF ON A SEPARATE SHEET AND ATTACH IT TO THIS FORM.

IF A SETTLEMENT HAS BEEN OFFERED TO YOU, HOW MUCH WAS IT: \_\_\_\_\_

WHO WILL REPRESENT YOU AT THE HEARING, IF APPLICABLE

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

UNDER DELAWARE LAW. ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER WHO FILES A STATEMENT OR CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY

YOUR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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RETURN THE ORIGINAL AND THREE COPIES TO: DELAWARE INSURANCE DEPARTMENT, 841 SILVER LAKE BOULEVARD, DOVER, DELAWARE 19904

**REGULATION 11—FORM B**  
**RESPONSE TO PETITION FOR HEALTH INSURANCE ARBITRATION**

CASE NUMBER \_\_\_\_\_

CLAIMANT'S NAME \_\_\_\_\_

POLICYHOLDER'S NAME (if different from Claimant) \_\_\_\_\_

ADDRESS (if different from Claimant) \_\_\_\_\_

RESPONDENT'S

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

IF THE PETITION RELATES TO THE SERVICES OF AN INDIVIDUAL PHYSICIAN, INCLUDE THE FOLLOWING INFORMATION:

PHYSICIAN'S NAME AND PRACTICE GROUP \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

CLAIM NUMBER ASSIGNED BY RESPONDENT \_\_\_\_\_

DATE OF DETERMINATION OF INDEPENDENT REVIEW PROCESS \_\_\_\_\_

AMOUNT OF CLAIM ADMITTED BY RESPONDENT \_\_\_\_\_

DATES OF SERVICE (FROM) \_\_\_\_\_ (TO) \_\_\_\_\_

BRIEFLY DESCRIBE THE BASIS FOR YOUR RESPONSE/OBJECTION TO THE PETITION AND ATTACH THE NOTIFICATION OR EXPLANATION OF BENEFITS YOU PROVIDED TO THE CLAIMANT \_\_\_\_\_

\_\_\_\_\_

PRIOR TO THE HEARING, IT IS NECESSARY THAT YOU SUBMIT THE APPROPRIATE DOCUMENTS TO SUPPORT YOUR PETITION TO THE DELAWARE INSURANCE DEPARTMENT AND TO THE OPPOSING PARTY.

PARTIES MAY PRESENT WITNESSES IN THEIR BEHALF AT THE HEARING PROVIDED THAT DUE NOTICE IS GIVEN. PLEASE LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL WITNESSES YOU EXPECT TO APPEAR ON YOUR BEHALF ON A SEPARATE SHEET AND ATTACH IT TO THIS FORM.

IF A SETTLEMENT HAS BEEN OFFERED TO YOU, HOW MUCH WAS IT: \_\_\_\_\_

WHO WILL REPRESENT YOU AT THE HEARING

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

UNDER DELAWARE LAW. ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER WHO FILES A STATEMENT OR CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY

YOUR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RETURN THE ORIGINAL AND THREE COPIES TO: DELAWARE INSURANCE DEPARTMENT, 841 SILVER LAKE BOULEVARD, DOVER, DELAWARE 19904

**REGULATION 11—FORM C**  
**PROOF OF SERVICE OF PAPERS REQUIRED FOR ARBITRATION**

I certify that on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, in addition to the filing provided to the Insurance Commissioner, I sent a copy of the

\_\_\_\_\_ Complaint for Arbitration with required attachments

\_\_\_\_\_ Response to the Complaint for Arbitration with required attachments

\_\_\_\_\_ Other (please describe) \_\_\_\_\_

\_\_\_\_\_

to the following person(s) by certified mail, return receipt requested:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The following is required by the person making this certification

Name of Party \_\_\_\_\_

Signature of Party \_\_\_\_\_

Address of Party \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE: Save all proofs of mailing and return receipt(s) for verification by the Arbitrator.**

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